

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If no deputy is necessary, the Medical Director, writing the word "pending" in pencil in item 18, Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
11849 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11834									
1. PLACE OF DEATH a. COUNTY <b>St. Marys</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <del>XXXXXX</del> <b>Great Mills</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Valley Lee</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Rural</b>					d. STREET ADDRESS <b>Rural</b>				
3. NAME OF DECEASED (Type or print) <b>Herman Jerome Barnes</b>					4. DATE OF DEATH <b>October 11, 19 61</b>				
5. SEX <b>male</b>					6. COLOR OR RACE <b>negro</b>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <b>11/11/1911</b>				
9. AGE (In years last birthday) <b>49</b> yrs.					10. IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>General</b>				
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>					12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>Ernest Barnes (dec)</b>					14. MOTHER'S MAIDEN NAME <b>Edith Anderson (dec)</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war/dates of service) <b>no</b>					16. SOCIAL SECURITY NO. <b>578 12 8799</b>				
17. INFORMANT <b>Mary E. Barnes - Lexington Park, Md.</b>					18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gun Shot</b> 981X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>SHOT DURING ARGUMENT</b>				
20c. TIME OF INJURY Month, Day, Year <b>10/10 19 61</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>HOME</b>					20f. (City or town) (County) (State) <b>GREAT MILLS ST. MARYS MD</b>				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Wm. D. Boyd, MD</b>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>Wm. D. Boyd, MD</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					22b. DATE THEREOF <b>10/16/61</b>				
22c. NAME OF CEMETERY OR CREMATORY <b>Both Thursday Cem.</b>					22d. LOCATION (City, town, or country) (State) <b>Valley Lee, Maryland</b>				
23. FUNERAL DIRECTOR <b>P.B. Robinson - Leonardtown, Md.</b>					24a. REC'D BY REGISTRAR <b>10/18/61</b>				
					24b. REGISTRAR'S SIGNATURE <b>William S. Hanna</b>				

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

11856

11835

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Callaway</b>				c. LENGTH OF STAY IN 1b <b>6 hrs</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Great Mills</b>			
				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <b>Florence Mary Chase</b>				4. DATE OF DEATH Month <b>October</b> Day <b>10</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 10, 1913</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <b>48</b> yrs.		11. BIRTHPLACE (State or foreign country) <b>Maryland U.S.A.</b>	
13. FATHER'S NAME <b>James Green</b>				14. MOTHER'S MAIDEN NAME <b>Whalen</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-24-3247</b>		17. INFORMANT <b>Mrs Louise G Briscoe</b>		Address <b>Great Mills, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>30 min.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>W.H. Patmick</b>		M.D. ASSISTANT MEDICAL EXAMINER <b>A.S.</b>		DEPUTY MEDICAL EXAMINER		DATE SIGNED <b>10-11-61</b>	
EXAMINER'S NAME (Type)		Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/12/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Face Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Great Mills, Md.</b>	
23. FUNERAL DIRECTOR <b>W. Clarke Mattingley</b>				ADDRESS <b>Leonardtown, Maryland</b>		24a. REC'D BY REGISTRAR <b>OCT 13 '61</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

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MEDICAL CERTIFICATION

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U.S. District Court, Northern District of California

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

FOR STATE  
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>St. Marys</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Tall Timbers</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Tall Timbers</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Rural</b>		d. STREET ADDRESS <b>Rural</b>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM - COURT</b>		4. DATE OF DEATH Month <b>October</b> Day <b>31</b> Year <b>19 61</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 8, 1885</b>
9. AGE (In years last birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Plumbing</b>	
11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Emil E. Court (dec)</b>		14. MOTHER'S MAIDEN NAME <b>Julia A. Shellhorn (dec)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1915-1920 214 30 2397</b>	
17. INFORMANT <b>Edward Court</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <b>Coronary Infarct.</b>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4204</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>6 HR</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Wm. D. Boyd, MD</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Wm. D. Boyd, MD</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>11/1/61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/6/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or country) (State) <b>Arlington, Va.</b>	
23. FUNERAL DIRECTOR <b>P.B. Robinson - Leonardtown, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 7 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>William S. Thomas</b>			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11852 CERTIFICATE OF DEATH 11837											
Item 9 Film G297 10/23/61 mh											
1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b> c. LENGTH OF STAY IN 1b <b>1 1/2 hrs.</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> f. COUNTY <b>St. Mary's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Lexington Park</b> d. STREET ADDRESS <b>Rt 1, Box 50</b>							
3. NAME OF DECEASED (Type or print) <b>St. Mary's Hospital</b> First Middle Last				4. DATE OF DEATH <b>October 12, 1961</b> Month Day Year				9. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 12, 1961</b> last birthday		9. AGE (In years IF UNDER 1 YEAR last birthday) <b>1</b> Months <b>28</b> Days <b>1</b> Hours <b>28</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>			
13. FATHER'S NAME <b>Raymond L. Holford</b>				14. MOTHER'S MAIDEN NAME <b>Mary Evelyn Whalen</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <b>Mother</b>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brain Damage</b> <b>761'D</b> DUE TO <b>A. noxia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Premature Separation of Placenta</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <b>10/12/61</b> to <b>10/12/61</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>10/12/61</b> , and that death occurred at <b>4:30 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>James P. Jarboe M.D.</b>				22b. DATE SIGNED <b>10/12/61</b>				22c. PHYSICIAN'S NAME (Type) <b>James P. Jarboe M.D.</b>			
22d. ADDRESS <b>Great Mills, Maryland</b>				23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>							
23b. DATE THEREOF <b>Oct. 13, 1961</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Holy Face Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Great Mills, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>				ADDRESS <b>Leonardtown, Maryland</b>				25a. REC'D BY REGISTRAR <b>OCT 19 '61</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kinn</b>											

207 P212 X18

11352

(M)

St. Mary's

Leominster

St. Mary's Hospital

(1)

July

July

Leominster

October 12

October 12, 1901

October

Male

U.S.A.

Maryland

Mary Evelyn Jones

Raymond L. Hildred

Mother

Same as 42

James F. Jones M.D.

Great Mills, Maryland

Arrival

Oct. 12, 1901 Holy Face Cemetery

Great Mills, Md.

W. Clarke Nettling, Leominster, Maryland



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 20 Film 299  
11-1-61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
11853

11838

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Great Mills</b> c. LENGTH OF STAY IN 1b <b>3 weeks</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Ridge</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>David</b> Middle <b>Glen</b> Last <b>Keister</b>			4. DATE OF DEATH Month <b>October</b> Day <b>17</b> Year <b>19 61</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 7, 1961</b>		9. AGE (In years last birthday) <b>4</b> yrs. IF UNDER 1 YEAR Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>			
13. FATHER'S NAME <b>Ronnie O. Keister</b>		14. MOTHER'S MAIDEN NAME <b>Joan P. Carroll</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mother</b> Address <b>Same as # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> <b>923.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Respiratory obstruction</b> (c) <b>Inhalation of wool from blanket</b>					INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>minutes</b> <b>minutes</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I, or Part II of Item 18.) <b>Evidently, after waking early in A.M. child began pulling wool from blanket on bed. Much wool was found in child's fingers and mouth.</b>					
20c. TIME OF INJURY Month, Day, Year <b>6-8 AM 10-17 1961</b>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home - in bed</b>		20e. (City or town) <b>Great Mills St. Marys</b> (State) <b>Md</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>July 1961</b> to <b>Oct 17, 1961</b> , that (I) (we) last saw the deceased alive on <b>Oct 17, 1961</b> , and that death occurred at <b>AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>James P. Jarboe</b>		22b. ADDRESS <b>Great Mills, Maryland</b>		22c. PHYSICIAN'S NAME (Type) <b>James P. Jarboe M.D.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct. 20, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. James Cemetery</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>		ADDRESS <b>Leonardtwn, Maryland</b>		25a. REC'D BY REGISTRAR <b>OCT 24 '61</b>			
25b. REGISTRAR'S SIGNATURE <b>William S. Kross</b>							

VR A15 (4)  
15M 9/60

11883

MI

St. Mary's

Maryland

St. Mary's

St. Mary's

St. Mary's

St. Mary's

David

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

St. Mary's

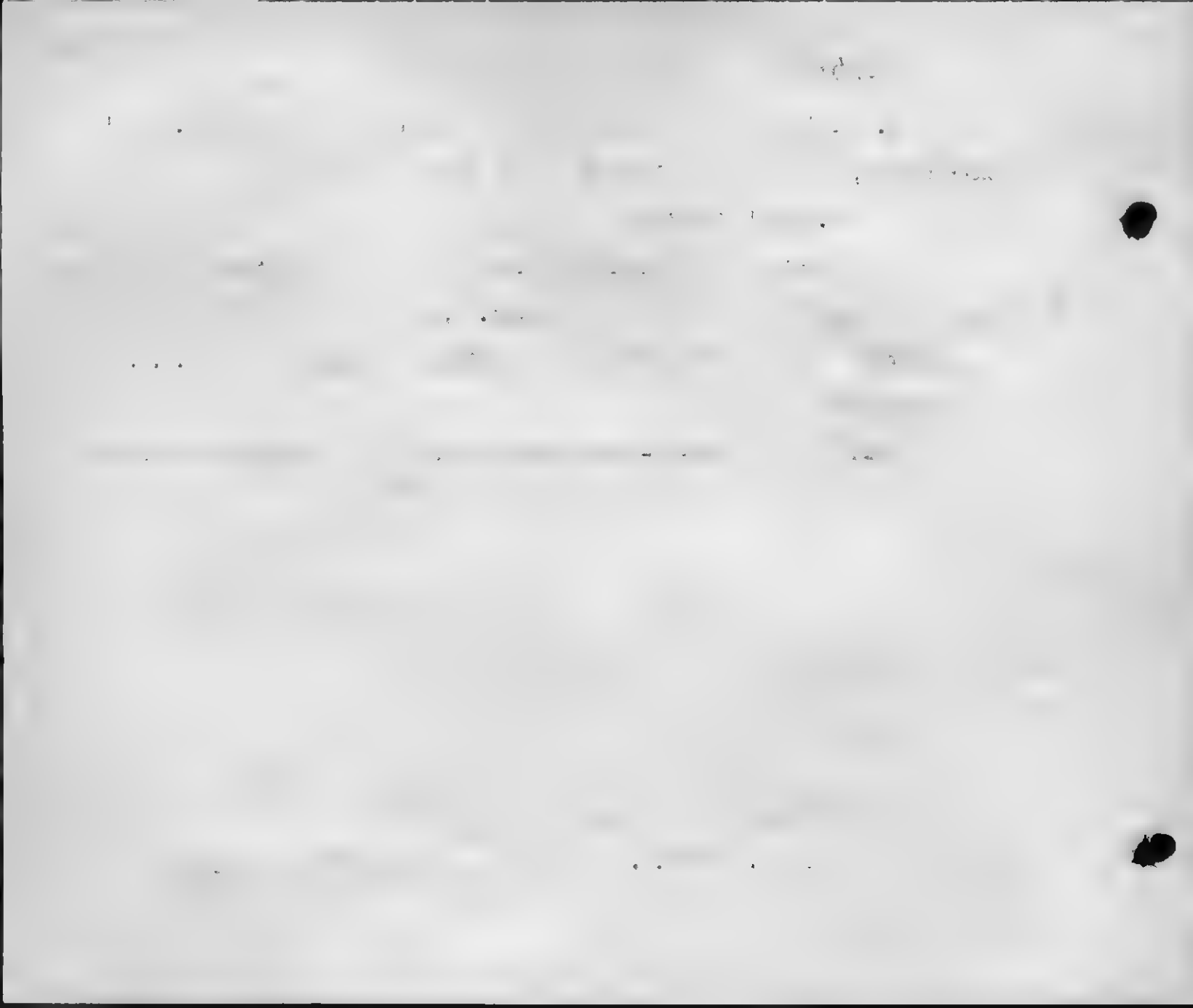
St. Mary's

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11854 <u>Item 14 Film 6-11-61 ink</u> <span style="float: right;">1855</span>											
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)							
a. COUNTY <b>St. Mary's</b>				a. STATE <b>Maryland</b>				b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn,</b>				c. LENGTH OF STAY IN 1b <b>12 days</b>				d. Y OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Leonardtown</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Mary's Hospital</b>				e. STREET ADDRESS				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Louis Edward Lotz</b>				4. DATE OF DEATH <b>October 22, 1961</b>				5. AGE (In years last birthday) <b>67</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS.			
5. SEX <b>Male</b>				6. COLOR OR RACE <b>White</b>				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Civil Service</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>			
13. FATHER'S NAME <b>Henry Lotz</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>				16. SOCIAL SECURITY NO <b>215-07-5064</b>				17. INFORMANT <b>Anna H. Lotz</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) <b>Coronary occlusion</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO				PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO				INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO				Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year <b>10-14-1961</b>				20d. INJURY OCCURRED <b>While at work</b>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) <b>Leonardtwn,</b>				20g. (County) <b>Md.</b>				20h. (State) <b>Md.</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>10-14-1961</b> to <b>10-22-1961</b> , that (I) (we) last saw the deceased alive on <b>10-22-1961</b> , and that death occurred <b>at 4 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>William D. Boyd</b>				22b. DATE SIGNED <b>10/23/61</b>				22c. PHYSICIAN'S NAME (Type) <b>William D. Boyd M.D.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>10-25-61</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Hattingly</b>				24. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Hattingly</b>				25a. REC'D BY REGISTRAR <b>10/26/61</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>				25c. LOCATION (City, town or county) <b>Balto.</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

11855

11840

### 1. PLACE OF DEATH

a. COUNTY

St Marys

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Charlotte Hall

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

### 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

Maryland

b. COUNTY

St Marys

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Charlotte Hall

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

### 3. NAME OF DECEASED (Type or print)

First

Charles

Middle

Columbus

Last

Lucas

### 4. DATE OF DEATH

Month

Oct

Day

3

Year

1961

### 5. SEX

Male

### 6. COLOR OR RACE

White

### 7. MARRIED

NEVER MARRIED ☒

### 8. DATE OF BIRTH

June 28, 1889

### 9. AGE (In years, last birthday)

72 yrs.

### 10. IF UNDER 1 YEAR

Months

Days

Hours

Min.

### 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Farmer

### 10b. KIND OF BUSINESS OR INDUSTRY

Farming

### 11. BIRTHPLACE (County & State or foreign country)

Charles County MD U.S.A.

### 12. CITIZEN OF WHAT COUNTRY?

### 13. FATHER'S NAME

Columbus Lucas

### 14. MOTHER'S MAIDEN NAME

Martha Ann Jenkins

### 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service)

No

### 16. SOCIAL SECURITY NO.

None

### 17. INFORMANT

Mrs. Margaret Cargill, Address Charlotte Hall, Md

### 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

#### PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

Cerebral Arterio Sclerosis

334X DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

Hypostatic Pneumonia

(c)

#### PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

#### INTERVAL BETWEEN ONSET AND DEATH

20 years

3 days

### 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

### 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

### 20c. TIME OF INJURY

Month, Day, Year

Hour a.m. p.m.

19

### 20d. INJURY OCCURRED

While at work ☐ Not While at work ☐

### 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

### 20f. (City or town)

### (County)

### (State)

21. I certify that (I) (this hospital) attended the deceased from August 16, 1961, to Oct. 3, 1961, that (I) (we) last saw the deceased alive on Sept. 30, 1961, and that death occurred at 10 M, from the causes and on the date stated above.

### 22a. SIGNATURE

William J. Kurz, M.D.

### ATTENDING PHYS.

### MED. DIRECTOR

### STAFF PHYS.

10-4-'61

### 22b. DATE SIGNED

### 22c. PHYSICIAN'S NAME (Type)

William J. Kurz, M.D.

### 22d. ADDRESS

La Plata, Maryland

### 23a. BURIAL, CREMATION, REMOVAL (Specify)

### 23b. DATE THEREOF

Burial Oct. 7, 1961 St. Marys cem.

### 23c. NAME OF CEMETERY OR CREMATORY

### 23d. LOCATION (City, town or county)

Bryantown, Md.

### (State)

### 24. FUNERAL DIRECTOR'S SIGNATURE

### ADDRESS

Hunt Funeral Home, Waldorf, Md

### 25a. REC'D BY REGISTRAR

OCT 10 '61

### 25b. REGISTRAR'S SIGNATURE

Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



51  
212

37

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• • • •

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11856

## CERTIFICATE OF DEATH

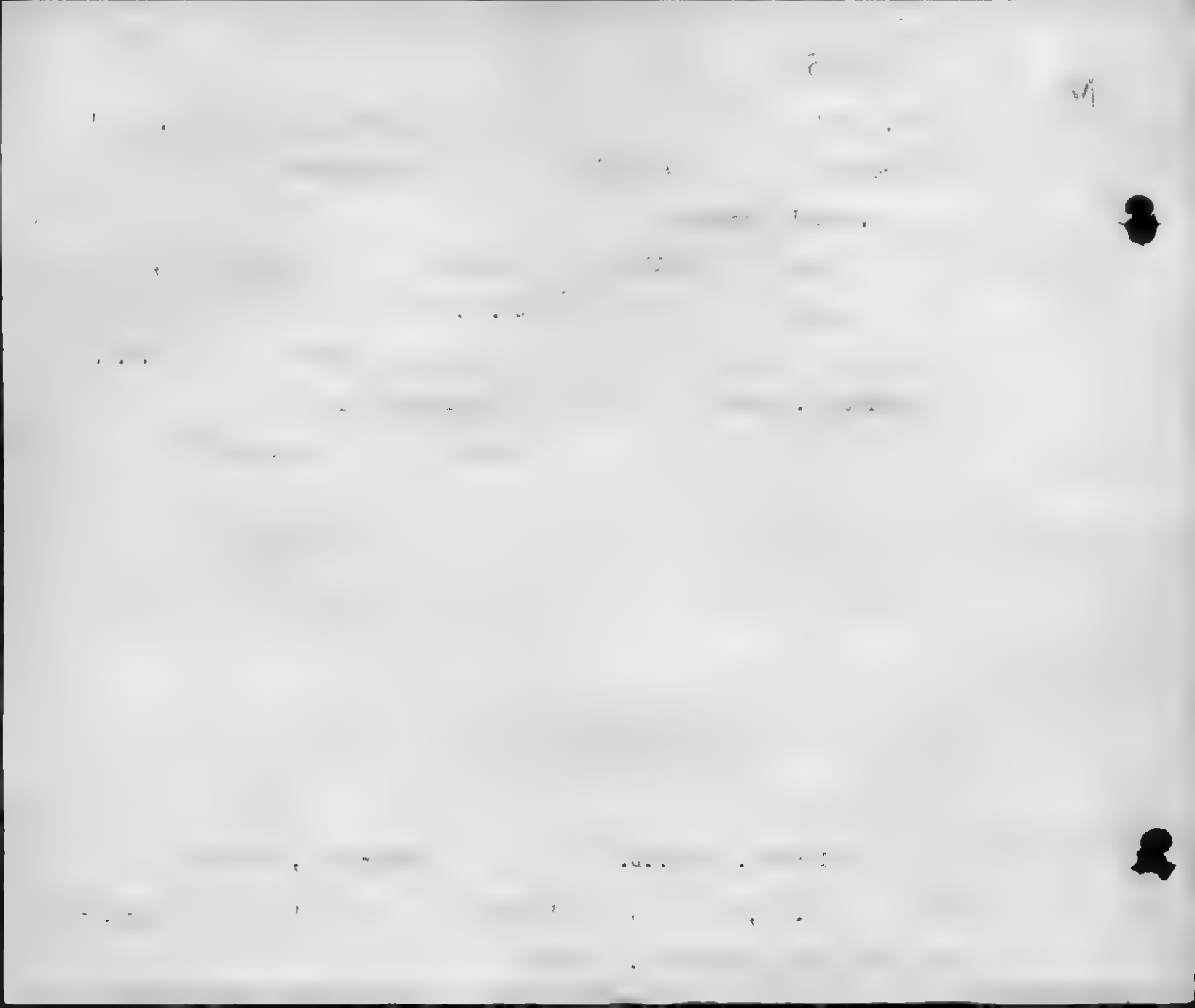
11841

Item 5 Film 0298 10/24/61 mb

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b> c. LENGTH OF STAY IN 1b <b>11 day</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Mary's Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b> d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Reed Silvin Owens</b>		4. DATE OF DEATH Month <b>October</b> Day <b>15</b> Year <b>1961</b>		9. AGE (In years, if under 1 year; if under 24 hours, last birthday) Years <b>9</b> Months <b>26</b> Days <b>26</b> Hours <b>26</b> Min.	
5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 19, 1960</b> 10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		13. FATHER'S NAME <b>Charles B. Ownes</b> 14. MOTHER'S MAIDEN NAME <b>Julia Mae Wilson</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> 16. SOCIAL SECURITY NO. <b>same as # 2</b> 17. INFORMANT <b>Mother</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO (b) <b>same as # 2</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <b>same as # 2</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e).		INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <b>10/14/1961</b> Hour a.m. <b>19</b> p.m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10/14/1961</b> to <b>10/15/1961</b> , that (I) (we) last saw the deceased alive on <b>10/14/1961</b> , and that death occurred at <b>11 A.M.</b> from the causes and on the date stated above.		22a. SIGNATURE <b>William D. Boyd M.D.</b> 22c. PHYSICIAN'S NAME (Type) <b>William D. Boyd M.D.</b>		22b. DATE SIGNED <b>10/16/61</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>Leonardtown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct. 17, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Our Lady's Chapel</b>	
23d. LOCATION (City, town or county) <b>Medley's Neck, Maryland</b>		23e. REC'D BY REGISTRAR <b>W. Clarke Mattingley</b>		23f. REGISTRAR'S SIGNATURE <b>Leonardtown, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>		24a. ADDRESS <b>Leonardtown, Maryland</b>		24b. DATE <b>OCT 19 '61</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60









TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

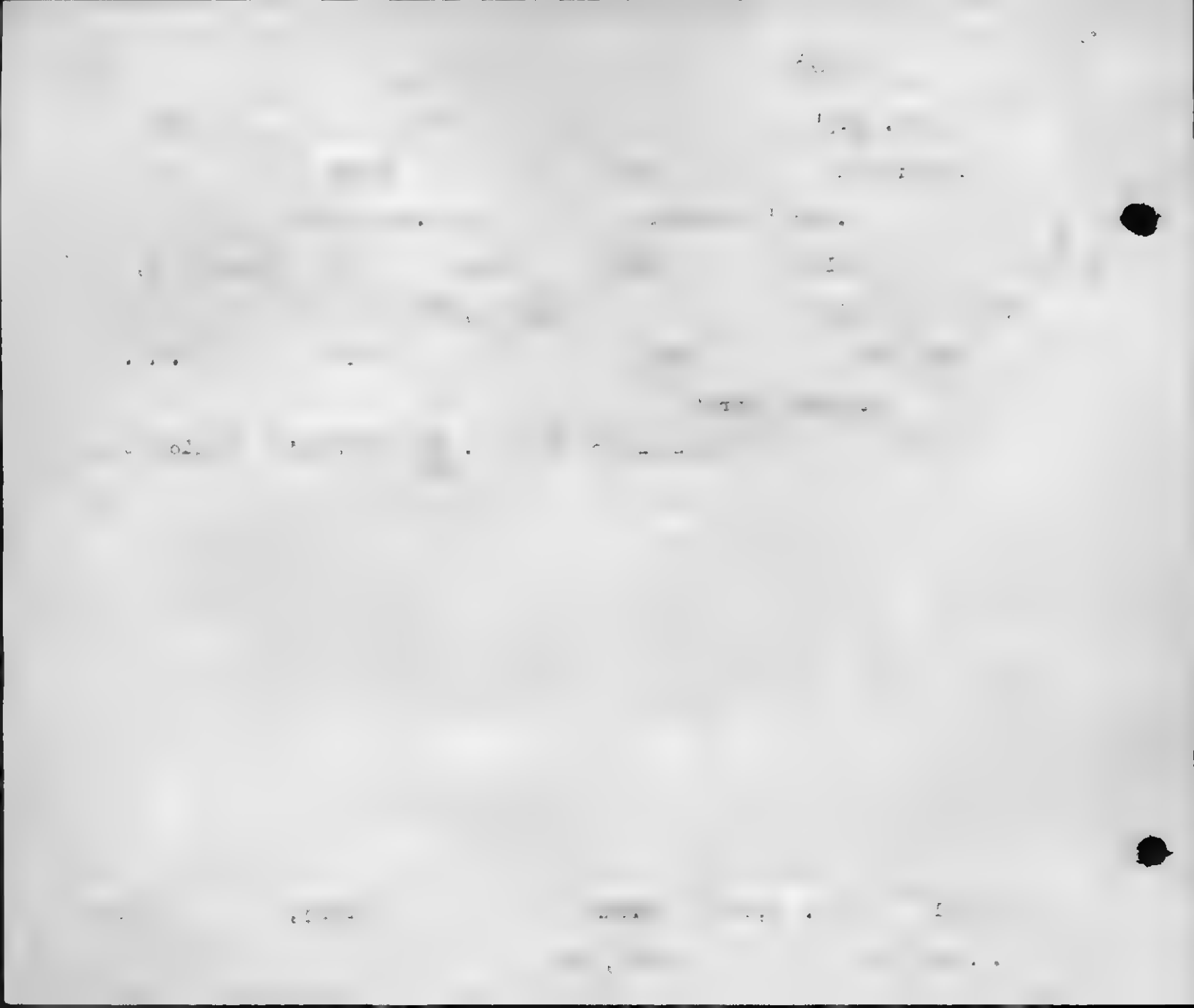
## CERTIFICATE OF DEATH

11858

Item 11, Film G297 10/23/61 rh

11843

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b> c. LENGTH OF STAY IN lb <b>8 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Mary's Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Ohio</b> b. COUNTY <b>Miami</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Piqua</b> d. STREET ADDRESS <b>1232 S. Roosevelt</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Elva</b> 4. DATE OF DEATH <b>October 11, 19 61</b>		5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>July 20, 1895</b> 9. AGE (In years last birthday) <b>66</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b> 11. BIRTHPLACE (County & State, or foreign country) <b>Ohio</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Eliphalet Penrod</b> 14. MOTHER'S MAIDEN NAME <b>Ella Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> 16. SOCIAL SECURITY NO. <b>291-24-3279</b> 17. INFORMANT <b>Robert N. Shaw</b> Address <b>143 Rolling Road, Town Creek, Lex.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Generalized Carcinomatosis</b> DUE TO <b>Carcinoma of uterus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>10 mos.</b> (c) <b>10 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>10-3-61</b> to <b>10-11-61</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>10-11-61</b> 19 <b>61</b> , and that death occurred at <b>5 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>W.H. Patrick</b> 22c. PHYSICIAN'S NAME (Type) <b>W.H. PATRICK</b>		22b. DATE SIGNED <b>10-11-61</b> 22d. ADDRESS <b>LEXINGTON PARK, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>Oct. 14, 1961</b> 23c. NAME OF CEMETERY OR CREMATORY <b>SPRING</b> 23d. LOCATION (City, town or county) (State) <b>Sidney, Ohio</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>J.C. Cron &amp; Son</b> ADDRESS <b>Piqua, Ohio</b> 25a. REC'D BY REGISTRAR <b>OCT 13 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraw</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, pay the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

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11859

11844

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>St. Marys</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hughesville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Marys Hospital</b>		d. STREET ADDRESS <b>Rural</b>	
3. NAME OF DECEASED (Type or print) First <b>PETER</b> Middle <b>PIERRE</b> Last <b>SMITH</b>		4. DATE OF DEATH Month <b>October</b> Day <b>15</b> Year <b>1961</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/19/1886</b>
9. AGE (In years last birthday) <b>74</b> yrs		10. IF UNDER 1 YEAR Months <b>74</b> Days <b>74</b> Hours <b>74</b> Min <b>74</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Peter P. Smith</b>		14. MOTHER'S MAIDEN NAME <b>Annie K. Biscoe</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>218 12 9757</b>	
17. INFORMANT <b>Catherine B. Smith - Hughesville, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Adenocarcinoma of prostate</b> DUE TO <b>177x</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <b>177x</b> (c) <b>177x</b>		INTERVAL BETWEEN ONSET AND DEATH <b>27 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1957</b> , 19 <b>Oct</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>15 Oct 1961</b> , and that death occurred at <b>8 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>D.L. Massman</b>		22b. DATE SIGNED <b>10/16/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>D.L. Massman, M.D.</b>		22d. ADDRESS <b>Mechanicsville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/18/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Marys City, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>P.B. Robinson - Leonardtown, Md.</b>		25a. REC'D BY REG STRAR <b>OCT 23 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		25c. DATE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11860

## CERTIFICATE OF DEATH

Reg. Dist. No. 13081

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>		c. LENGTH OF STAY IN 1b <b>X</b> <b>Hollywood</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Mary's Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Thomas</b>		4. DATE OF DEATH Month Day Year <b>10-29-1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-29-61</b>
9. AGE (In years lost birthday) <b>2</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>2 0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Raymond Joseph Thomas</b>		14. MOTHER'S MAIDEN NAME <b>Mary Cecelia Spears</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>I</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Mother</b>	
17. ADDRESS <b>Hollywood, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>776X Prematurity</b> DUE TO (b) <b>0J</b> DUE TO (c) <b>0J</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>50 min</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10-27</b> , 19 <b>61</b> , to <b>10-29</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>10/29</b> , 19 <b>61</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Dr. Wm. D. Boyd</b> M D		ADDRESS (Street, city or town, state) <b>Leonardtown</b> DATE SIGNED <b>11/2/61</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Wm. D. Boyd</b>		<b>Leonardtown</b>	
22a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-30-61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St Aloysius</b>		22d. LOCATION (City, town, or county) (State) <b>Leonardtown Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Family</b>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <b>NOV 9 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11861

## CERTIFICATE OF DEATH

Item 7 Film G297 10/23/61 mh

11845

<b>1. PLACE OF DEATH</b> a. COUNTY <b>St. Mary's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b> c. LENGTH OF STAY IN 1b <b>9 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Mary's Hospital</b>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Marys County</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hollywood</b> d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Carrie</b> Middle <b>Mae</b> Last <b>Vogt</b>			<b>4. DATE OF DEATH</b> Month <b>October</b> Day <b>16</b> Year <b>1961</b>		
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	
<b>8. DATE OF BIRTH</b> <b>Jan. 21, 1882</b>		<b>9. AGE</b> (In years last birthday) <b>79</b> yrs. IF UNDER 1 YEAR: Months <b>10</b> Days <b>16</b> Hours <b>16</b> Min.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b>  		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Virginia</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Christopher Curtin</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Elizabeth Hall</b>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service)		<b>16. SOCIAL SECURITY NO.</b>  		<b>17. INFORMANT</b> <b>Mrs Lona Waple Hollywood, Maryland</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  	
<b>20f. (City or town)</b>  		<b>20g. (County)</b>  		<b>20h. (State)</b>  	
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <b>6/10</b> , 19 <b>60</b> , to <b>10/16</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>10/15</b> , 19 <b>61</b> , and that death occurred at <b>3 A.M.</b> , from the causes and on the date stated above.					
<b>22a. SIGNATURE</b> <b>William D Boyd</b> M.D.			<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>10/16/61</b>
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>WILLIAM D BOYD</b>			<b>22d. ADDRESS</b> <b>LEONARDTOWN</b>		<b>22e. (State)</b> <b>MD</b>
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>10/18/1961</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Ivy Hill Cemetery</b>	
<b>23d. LOCATION</b> (City, town or county) <b>Alexandria, Virginia.</b>		<b>23e. (State)</b>  			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>John W. Murphy</b>			<b>ADDRESS</b> <b>Alexandria, Va.</b>		
<b>25a. REC'D BY REGISTRAR</b> <b>OCT 18 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kneass</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/60

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(M)

St. Mary's

9 days

Leonardson

St. Mary's Hospital

October 10, 1935

York

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Carric

79

Jan. 21, 1935

White

Female

U.S.A.

Virginia

Elizabeth Hall

Christophers Curtis

(I)

New Bone Wagon, Hollywood, Maryland

*Handwritten signature*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

(M)

078

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11862 CERTIFICATE OF DEATH 11846											
1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b> c. LENGTH OF STAY IN 1b <b>7 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Mary's Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Leonardtown</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Clarence</b> First Middle Last				4. DATE OF DEATH <b>October 16, 19 61</b> Month Day Year							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 15, 1891</b> yrs. Months Days Min.		9. AGE (In years last birthday) <b>70</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>day work</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Charles County, Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Charles Yorkshire</b>				14. MOTHER'S MAIDEN NAME <b>Josephine Herbert</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes give year or dates of service) <b>WWL</b>				16. SOCIAL SECURITY NO. <b>W W L</b>		17. INFORMANT <b>Joseph H. Yorkshire Mechanicsville, Maryland</b> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> <b>422.1</b> DUE TO (b) <b>Arteriosclerotic cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b> <b>10 yrs.</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 19 <b>61</b> , to <b>Oct</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>16 Oct</b> , 19 <b>61</b> , and that death occurred at <b>10</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>Joseph E. Gill</b>				M.D. <b>Joseph E. Gill M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>10/19/61</b>			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <b>Leonardtwn, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10.18.61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Aloysius</b>		23d. LOCATION (City, town or county) <b>Leonardtwn, Md.</b>		23e. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>				ADDRESS <b>Leonardtwn, Maryland</b>		25a. REC'D BY REGISTRAR <b>OCT 19 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

11008



St. Mary's

Maryland

St. Mary's

Memorandum

7 days

Annual Record

St. Mary's Hospital

Diagnosis

locksmith

October 10, 1911

Male

Colored

March 18, 1911

70

Latent

day work

Charles County, Md.

U.S.A.

Charles Locksmith

Josephine Locksmith

Age 70

Joseph M. Locksmith, Mechanicsville, Maryland

History of Present Illness

Memorandum, Maryland

Joseph M. Locksmith

Memorandum, Maryland

St. Mary's

October 10, 1911

Male

W. Olin Locksmith, Mechanicsville, Maryland